American Association of Orthodontists

History Form for Patient with Temporomandibular Disorder

Date _____

Name _____ Birth date _____

What problems do you have with your jaw joints, jaw muscles and/or teeth? _____

When did these problems start? _____

What do you think caused these problems? _____

SYMPTOMS Please mark each symptom that applies.

Jaw Joint Problems	**Left**		**Right**		
Joint clicking or popping	☐Yes	☐No	☐Yes	☐No	Comments _____
Grating noises	☐Yes	☐No	☐Yes	☐No	Comments _____
Jaw locks open	☐Yes	☐No	☐Yes	☐No	Comments _____
Jaw locks closed	☐Yes	☐No	☐Yes	☐No	Comments _____
Limited jaw opening	☐Yes	☐No	☐Yes	☐No	Comments _____
Jaw does not open smoothly	☐Yes	☐No	☐Yes	☐No	Comments _____
Soreness of jaw joints	☐Yes	☐No	☐Yes	☐No	Comments _____
Soreness of face muscles	☐Yes	☐No	☐Yes	☐No	Comments _____

Teeth Problems					
Teeth grinding	☐Yes	☐No	☐Yes	☐No	Comments _____
Teeth clenching	☐Yes	☐No	☐Yes	☐No	Comments _____
Soreness of one or more teeth	☐Yes	☐No	☐Yes	☐No	Comments _____
Looseness of one or more teeth	☐Yes	☐No	☐Yes	☐No	Comments _____

Head and Facial Pain	**Left**		**Right**		**(least) Degree of Pain (most)**
Migraine type headache	☐Yes	☐No	☐Yes	☐No	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Cluster headaches	☐Yes	☐No	☐Yes	☐No	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Sinus headaches	☐Yes	☐No	☐Yes	☐No	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Headaches in back of head	☐Yes	☐No	☐Yes	☐No	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Hair and/or scalp painful to touch	☐Yes	☐No	☐Yes	☐No	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Ear or Balance Problems			
Pain in ear	☐Yes	☐No	Comments _____
Ringing or buzzing	☐Yes	☐No	Comments _____
Clogged or stuffy ears	☐Yes	☐No	Comments _____
Diminished hearing	☐Yes	☐No	Comments _____
Dizziness or vertigo	☐Yes	☐No	Comments _____

Poor sense of balance ☐Yes ☐No Comments _____

Throat Problems

Swallowing difficulty ☐Yes ☐No Comments _____
Throat tightness ☐Yes ☐No Comments _____
Throat soreness ☐Yes ☐No Comments _____
Laryngitis ☐Yes ☐No Comments _____
Voice fluctuations ☐Yes ☐No Comments _____
Throat congestion ☐Yes ☐No Comments _____
Frequent cough ☐Yes ☐No Comments _____
Frequent throat clearing ☐Yes ☐No Comments _____
Excessive salivation ☐Yes ☐No Comments _____
Tongue pain ☐Yes ☐No Comments _____
Pain in roof of mouth ☐Yes ☐No Comments _____

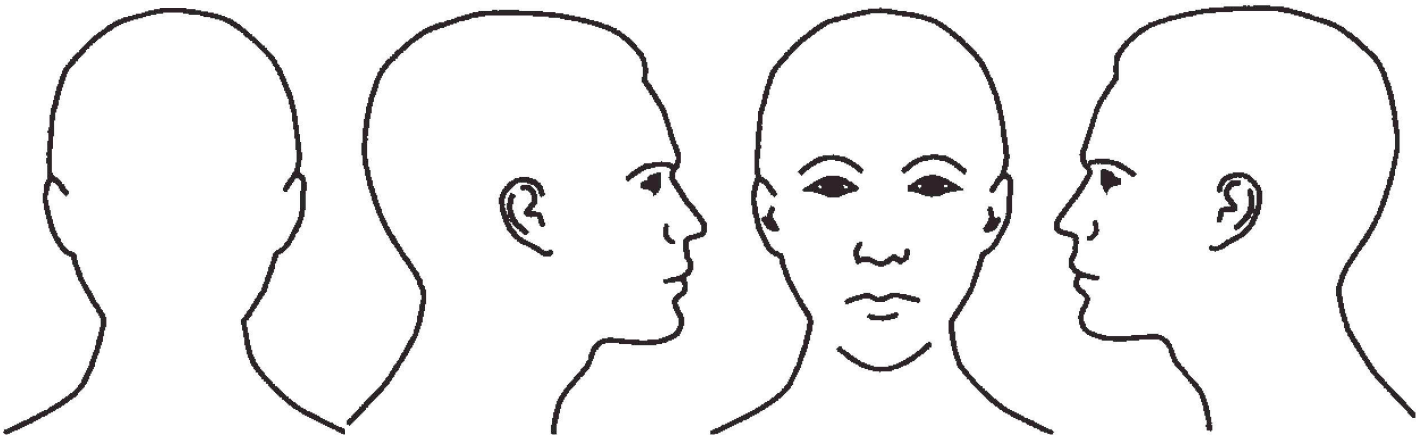
Neck and/or Shoulder Pain

Neck/shoulder/back pain ☐Yes ☐No Comments _____
Neck/shoulder/back reduced mobility ☐Yes ☐No Comments _____
Frequent neck muscle fatigue ☐Yes ☐No Comments _____
Arm or finger tingling, numbness, pain ☐Yes ☐No Comments _____

Eye Problems

Pain around or behind eyes ☐Yes ☐No Comments _____
Bloodshot eyes ☐Yes ☐No Comments _____
Blurred vision ☐Yes ☐No Comments _____
Pressure behind eyes ☐Yes ☐No Comments _____
Light sensitivity ☐Yes ☐No Comments _____
Watering of eyes ☐Yes ☐No Comments _____
Drooping of eyelids ☐Yes ☐No Comments _____

On the figures below, mark an X where you have pain. Circle the X where the pain is most severe.



PATIENT HEALTH INFORMATION

Do you have any recent or childhood history of trauma to the head or face (such as falls, auto accident, blows to the head or face, sports injury)? If yes, please describe: _____

Do you have a frequent activity that causes you to hold your head or neck in an imbalanced position (such as playing instrument, keyboarding, holding phone, etc)? If yes, please describe: _____

Have you been treated for a TMD problem before? If so, when? _____ By whom? _____

Was the problem the same or different than your current problem? _____

What treatment did you have? _____

Do you think the treatment was successful? _____

What would you like your treatment here to achieve? _____

UPDATES

Updates _____
Patient Signature _____ Date_____
Dental Staff Signature _____ Date_____

Updates _____
Patient Signature _____ Date_____
Dental Staff Signature _____ Date_____

Updates _____
Patient Signature _____ Date_____
Dental Staff Signature _____ Date_____